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Multiple Institutional Logics in Health Care: 'Productive Ward: Releasing Time to Care'

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Abstract

Health care organizations are often confronted with multiple institutional logics. In this study, a longitudinal case study method was used to gain insights into the adoption decision-making and implementation process of an apparently hybrid innovative practice when multiple logics are present. The case study focuses on the adoption and implementation of 'Productive Ward: Releasing Time to Care' in a Dutch hospital. This is a quality improvement programme developed by the National Health Service (NHS) in the United Kingdom. The results show that institutional logics complicate the adoption and implementation process.

Key words

Innovation, institutional logics, Productive Ward, health care

MULTIPLE INSTITUTIONAL LOGICS IN HEALTH CARE

'Productive Ward: Releasing Time to Care'

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INTRODUCTION

As a result of developments in their sector, public organizations are being confronted with competing values (Van der Wal *et al.*, 2011). The health care sector is a striking example of a public organizational field where multiple values and demands are at play. Hospitals in many countries are confronted with the challenge to simultaneously enhance the quality and reduce the costs of care. One of the drivers of this development in the Netherlands is the 2006 health care act, forcing Dutch hospitals to consider the cost aspects of care. These developments are also taking place in other countries, such as New Zealand and the United Kingdom. In these countries, New Public Management-inspired reforms are restructuring health care (Doolin, 2001). Bekkers *et al.* (2011: 9) illustrate this by referring to the health care sector when discussing the ‘introduction of a stronger market orientation’ (9). In addition, Noordegraaf (2007: 773) notices that ‘businesslike managerialism’ and ‘traditional professional values’ are being combined in public organizations. From a theoretical point of view, the institutional logics perspective might be used to analyse these developments in public sector organizations such as hospitals (Thornton *et al.*, 2012). Institutional logics can be defined as ‘the belief systems and associated practices that predominate in an organizational field’ (Scott *et al.*, 2000: 170). Scott *et al.* (2000) observed a shift from dominance of a professional logic to dominance of a managerial logic through market mechanisms in health care. Furthermore, several authors suggest that health care is an organizational field where multiple institutional logics exist (e.g. Reay and Hinings, 2005, 2009), i.e. an institutional complex field. Reay and Hinings (2009) for example show that both professional and business-like logics coexist in a Canadian health care system. It is expected that in hospitals, physicians and nurses might be acting in accordance with a professional logic that emphasizes the quality of care, while managers and directors might take on a more business-like logic, which is mainly occupied with efficiency (Ruef and Scott, 1998).

Several researchers conclude that research is needed to increase our knowledge about the ways in which organizations respond to multiple institutional logics (e.g. Greenwood *et al.*, 2011; Lounsbury, 2007). While research has been undertaken to explore the adoption and implementation processes of innovations in the health care sector (e.g. Greenhalgh *et al.*, 2004; Jespersen *et al.*, 2002), the adoption and implementation of innovative practices from a multiple institutional logics perspective is still relatively unexplored. Therefore, this study aims to contribute to the existing knowledge by studying the adoption and implementation of an apparently hybrid practice in a context where multiple institutional logics are at play.

In the literature, several clues are provided that make it likely that institutional complexity affects innovation adoption and implementation. First of all, the linkage between logics and practices is well established; organizational practices are seen as manifestations of institutional logics (Greenwood *et al.*, 2010; Lounsbury, 2007). In addition, logics are expected to determine the appropriateness of practices (Greenwood

et al., 2011). Moreover, it is expected that institutional logics affect organizational decision-making by steering the attention of decision-makers (e.g. Ocasio, 1997; Thornton, 2002). For example, Thornton (2002) expects that when one logic is dominant, the attention of decision-makers is directed towards issues and practices consistent with this logic. This makes us wonder what would happen when an organization experiences multiple logics. Adoption and implementation could result in possible tensions, contradictions and ambiguities, because different organizational stakeholders will be influenced by different logics. This study combines the innovation and the institutional logics perspective to study the adoption and implementation of an innovative practice in an institutional complex context where both business-like and professional logics are expected to be present, namely the health care sector. More specifically, we focus on the innovative practice 'Productive ward: Releasing Time to Care', which in its appearance is a hybrid practice combining the business-like (productive ward) and professional (releasing time to care) logic. We use the institutional logics perspective as our prime theoretical focus, because we aim to address public sector developments from a different perspective and thereby add to the debate on health care management and governance.

The research question of this study is 'How does the presence of multiple logics affect the adoption decision-making and implementation process of an innovative practice in health care?' By focusing on multiple institutional logics, this study extends public management, innovation and institutional logics research.

To explore these issues, a longitudinal case study of 'Productive Ward: Releasing Time to care' in a Dutch hospital was performed. First of all, this article will proceed with theoretically embedding this study in the literature and introducing the context. After describing the methods, the results of the study will be presented. This will be followed with a discussion of the results and concluding remarks.

THEORETICAL FRAMEWORK

Institutional logics

The institutional logics perspective represents a research stream within new institutionalism (Friedland and Alford, 1991). While new institutionalism is being criticized for the limited attention for agency in studying organizations, the institutional logics perspective emphasizes the role of actors (e.g. Thornton *et al.*, 2012). As Scott *et al.* (2000: 170) state: 'Institutional logics refer to the belief systems and associated practices that predominate in an organizational field'. Greenwood *et al.* (2010: 2) explain that 'logics underpin the appropriateness of organizational practices in given settings and at particular historical moments'. Research on this topic has for example focused on the ways institutional logics can guide the attention of organizational decision-makers (Ocasio, 1997) and paid attention to shifts in dominant logics in organizational fields (e.g. Scott *et al.*, 2000; Thornton and Ocasio, 1999).

Thornton *et al.* (2012: 4) state that ‘individuals and organizations, if only subliminally, are aware of the differences in cultural norms, symbols, and practices of different institutional orders and incorporate this diversity into their thoughts, beliefs and decision making. That is, agency, and the knowledge that makes agency possible, will vary by institutional order’. Markets and professions are examples of institutional orders (Thornton *et al.*, 2012). Often organizations experience multiple and sometimes conflicting institutional logics (Pache and Santos, 2010; Thornton and Ocasio, 2008). Research on this topic shows how organizations respond to and manage competing institutional logics (e.g. Pache and Santos, 2010; Saz-Carranza and Longo, 2012). Pache and Santos (2010) explain that organizations in organizational fields that are moderately centralized and highly fragmented are most likely to experience multiple institutional logics. Research (e.g. Reay and Hinings, 2009; Scott *et al.*, 2000) shows that health care is highly fragmented, i.e. that health care organizations are dependent on a high number of actors with possibly different logics (Pache and Santos, 2010). Also, this field appears to be moderately centralized because there is a dual authority structure, with public authorities and health care professionals as central actors (Pache and Santos, 2010). Therefore, it is expected that health care organizations are confronted with multiple institutional logics. In addition, Greenwood *et al.* (2011) state that in hospitals many different occupations are present that are likely to be influenced by different logics and that hospitals should be able to balance professional and business goals in order to be perceived as legitimate. Several authors indicate shifts in institutional logics in the health care field from a professional logic to a business-like logic. In addition, it is acknowledged that multiple institutional logics might coexist (e.g. Kitchener, 2002; Reay and Hinings, 2009; Ruef and Scott, 1998; Scott *et al.*, 2000). According to Kitchener (2002), the professional logic entails that ‘legitimacy was judged against criteria of prestige and the technical quality of the services provided’ (391). Goodrick and Reay (2011) emphasize that autonomy is an important aspect of a professional logic. The core aspects of the professional logic are high quality of care, sufficient time to spent directly on patients and autonomy (e.g. Goodrick and Reay, 2011; Kitchener, 2002). Alternatively, the business-like logic ascribes importance to practices that could lead to cost reduction (Reay and Hinings, 2009).

Competing or compatible institutional logics

Based on their review of empirical studies on institutional complexity, Greenwood *et al.* (2011: 332) conclude that most studies implicitly assume that logics are ‘inherently incompatible’. This is illustrated by their own definition of institutional complexity as situations where organizations are confronted with ‘incompatible prescriptions from multiple institutional logics’ (318).

However, there are indications that multiple logics can coexist and maybe even be combined within an organization or an organizational practice: so-called hybrids (e.g. Battilana and Dorado, 2010; Dunn and Jones, 2010; Goodrick and Reay, 2011).

A hybrid organization is an organization that combines different institutional logics (Battilana and Dorado, 2010). Next to the hybridization of an organization, it is also possible that organizational practices become hybridized, i.e. that multiple logics will be combined within one practice. An example of a hybrid innovative practice in the health care context is the clinical management role implemented in health care organizations (e.g. Kirkpatrick *et al.*, 2009). ‘Productive Ward: Releasing Time to Care’ also appears to be such a hybrid practice.

Innovation

Scholars define innovation in several ways (Crossan and Apaydin, 2010). These definitions all emphasize a newness aspect, primarily in terms of new to the organization that adopts it. For example, Damanpour (1991) defines innovation as ‘adoption of an internally generated or purchased device, system, policy, program, process, product, or service that is new to the adopting organization’ (556). In their review on innovation in health care, Lämsäsalmi *et al.* (2006) define innovation as ‘the intentional introduction and application within a role, group, or organisation, of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit the individual, the group, or wider society’ (67). Very early on, Schumpeter (1934) distinguished product innovation (a new good), process innovation (a new production method), market innovation (opening of a new market), input innovation (new source of input) and organizational innovation (new organization or industry). Another well-known distinction is that between technological and administrative innovations. Technological innovations refer to product, process and service innovations, whereas new procedures, policies and organizational forms can be regarded as administrative innovations (Damanpour and Evan, 1984; Damanpour, 1991). In this article, the definition of Damanpour (1991) is adopted. Therefore, ‘Productive Ward: Releasing Time to Care’ is viewed as an innovation, because it is a new practice for the adopting hospital. This innovation can be characterized as an administrative innovation, because it represents a new way for hospitals to enable nurses to make changes in their wards. Because little is known about the role of multiple logics in innovation processes of these types of innovations, the focus of this article will be on the role of multiple institutional logics in the adoption and implementation phases of this innovative practice. We use these phases as a heuristic framework to guide our research.

Institutional logics and the innovation adoption decision process

Adoption of an innovative practice can be defined as ‘the decision to make full use of an innovation as the best course of action available’ (Rogers, 2003: 177). According to the rational economic perspective, organizations will adopt innovations based on

information about their contribution to performance. This perspective explicitly takes into account the role of human agency and strategic choice in adoption decision processes (Child, 1972). Alternatively, research indicates that institutional logics could also influence adoption decisions. As Ocasio (1997) explains, institutional logics are capable of guiding the attention of organizational decision-makers to specific issues and affect decisions. This means that organizational actors convert the logics into action. Thornton (2002) and Goodrick and Reay (2011) support this view by explaining that logics play an important role in steering the attention of organizational actors. Goodrick and Reay (2011: 375) state that ‘logics shape individual and organizational practices because they represent sets of expectations for social relations and behavior. A core assumption is that the interests, identities and values of individuals and organizations are embedded in logics and provide the context for decisions and outcomes’. Therefore, institutional logics could play an important role in the adoption process by steering the attention of actors towards innovations that fit with their logic.

In public management literature, the distinction is made between logic of consequence and logic of appropriateness. The logic of consequence emphasizes the efficiency and effectiveness of innovations (Bekkers *et al.*, 2011; Bekkers and Korteland, 2008). In this view, adoption decisions are rational decisions based on balancing the cost and benefits of the innovation (Korteland, 2011). This logic shows many similarities to the rational economic perspective explained above. The logic of appropriateness emphasizes legitimacy and trustworthiness (Bekkers *et al.*, 2011; Bekkers and Korteland, 2008). Taking on this perspective, it is believed that the context of the organizations has a tremendous influence on the adoption decisions (Korteland, 2011), which is related to the institutional logics perspective. In this study, the institutional logics perspective will be used to study innovation adoption and implementation, because little research uses this perspective to focus on these processes. The adoption decision-making process might be complicated through the potential conflict between the different logics.

Institutional logics and the innovation implementation process

After the adoption decision has been made, the implementation process follows. The implementation of an innovation can be defined as ‘the early usage activities that often follow the adoption decision’ (Meyers *et al.*, 1999: 295). Kostova and Roth (2002: 217) distinguish two elements in this response to the adoption decision. First of all, the behavioural element, which is reflected by what they label implementation: ‘Implementation is expressed in the external and objective behaviors and the actions required, or implied, by the practice’ (217). Second, the attitudinal element, internalization, is the ‘internalized belief in the value of the practice’ (216) and represents an important predictor of the persistence of an innovation. According to these

authors, 'Internalization is that state in which the employees at the recipient unit view the practice as valuable for the unit and become committed to the practice' (Kostova and Roth, 2002: 217). Different combinations of internalization and implementation are proposed. For example, ceremonial adoption is the 'formal adoption of a practice on the part of the recipient unit's employees for legitimacy reasons, without their believing in its real value for the organization' (220). Ceremonial adoption combines a high level of implementation with a low level of internalization. A related concept is decoupling, which can be defined as 'a situation where compliance with external expectations is merely symbolic rather than substantive, leaving the original relations or practices within an organization largely intact and unchanged' (Han and Koo, 2010: 31). Both decoupling and ceremonial adoption refer to the superficial implementation of a new practice, possibly affected by institutional pressures to adopt the practice (e.g. Kostova and Roth, 2002). The presence of multiple institutional logics, both in the institutional context and in the innovative practice, might play an important role in determining the extent to which a new practice becomes implemented in the organization. This adopted practice might be only superficially implemented on the one hand or become actually internalized by organizational actors on the other hand. As Dearing (2009: 504) states, 'often in complex organizations, the users are not the choosers of the innovations. Implementers often subvert or contradict the intentions of the adopters'. This is especially relevant when the organization is confronted with multiple logics, because then it is more probable that the decision-makers will adhere to a different logic than the users of the new practice. For example, in health care organizations decision-makers are often the board members and directors, adhering to a business-like logic, while the users are primarily nurses, adhering to a nursing professional logic. These multiple logics might complicate the implementation process and affect the extent of implementation of innovative practices.

'Productive Ward: Releasing Time to Care'

In order to unravel the adoption and implementation processes of an innovative practice in a institutional complex context, we study a hospital that was among the first to adopt 'Productive Ward: Releasing Time to Care' in The Netherlands. This programme was developed in 2006 by the NHS Institute for Innovation and Improvement in the United Kingdom (NHS, 2010). The core assumption of the programme is that nursing staff organizes their own ward and improve processes themselves. This could increase the amount of time for direct patient care, which would result in a higher quality of care, more satisfied patients and nurses and a decreasing amount of waist. One of the core components of the programme was to enhance the empowerment and autonomy of nurses. Evaluations of the programme in the United Kingdom showed that empowerment of ward staff has increased due to the programme (Lipley, 2009). Empowerment

can be defined as ‘the psychological state of a subordinate perceiving four dimensions of meaningfulness, competence self-determination and impact, which is affected by empowering behaviours of the supervisor’ (Lee and Koh, 2001: 686). Research shows that empowerment is important for positive nursing outcomes, such as retention (e.g. Erenstein and McCaffrey, 2007).

This practice represents an innovative way for Dutch hospitals to initiate changes, by empowering nurses. It is especially interesting to investigate the adoption and implementation of this programme using an institutional logic perspective, because at first glance, the programme seems to combine the multiple logics health care organizations are confronted with. Research shows that communication plays an important role in the implementation of innovations in health care organizations (e.g. Damschroder *et al.*, 2009; Rogers, 2008). In this specific case, the way the programme is communicated throughout the organization refers to multiple institutional logics. That is, the labelling of the programme, ‘Productive Ward: Releasing Time to Care’, suggests that this could be an example of a hybrid practice that incorporates both the nursing professional logic (Releasing Time to Care) and the business-like logic (Productive Ward).

METHODS

Case study context

The pilot project ‘Productive Ward: Releasing Time to Care’ in the focal hospital is about implementing the first three modules (of a total of eight) within approximately 9 months in two wards. We decided to focus on this pilot phase, because we expected that the role of institutional logics in the adoption and implementation of the practice manifested itself especially in the early phases of implementation when the innovation is introduced. The first module is called ‘Knowing how we are doing’, where ward based measures are developed to make better informed decisions. The second module is called ‘Well-organized Ward’, which is about reorganizing and rearranging the ward. The third module, ‘Patient status at a glance’, aims to improve patient communication and flow. A project organization was set up to facilitate the implementation process, supported by an external consultancy agency.

This study was performed in a Dutch hospital. Dutch hospitals are not-for-profit organizations. Different types of hospitals (academic, top-clinical and general) exist, each with their own characteristics. The hospital under study is a top-clinical hospital, which performs highly specialized medical care. A two-tier governance model is adopted in these organizations, consisting of a board of directors and an independent board of supervisors. Traditionally, Dutch hospitals have a functional organization structure. However, more and more hospitals are changing their design towards a more process oriented structure (Veld, 2012).

Data collection and analysis

Two in-depth longitudinal case studies were carried out (Yin, 2008), because this enables the in-depth study of a real-life phenomenon and its context, which suits the research question. Both pilot wards are under study to be able to compare these wards.

Several data collection methods were used: semi-structured interviews, focus groups, document studies and observations. First of all, semi-structured interviews were conducted with project leaders, project team members and workgroup members (including ward nurses) from both wards, as well as the hospital director, communication advisor and an external consultant that facilitated the implementation process. In total, fifteen interviews were conducted, of which eight were conducted at the start and seven in the middle of the pilot programme. The key actors in the process were selected, and from each key actor group, one or more respondents were interviewed in order to provide a complete overview of the process from all perspectives. The interview questions primarily focused on the adoption decision process and the implementation process of the programme. Interviews lasted approximately 1.5 hours. Second, at the end of the pilot programme, two focus groups were conducted, in order to collect information on the implementation process with focus group members interacting with each other. One focus group of approximately 2.5 hours was organized for each pilot ward, with seven nurses, internal advisors and managers participating. In addition, relevant documents were analysed, such as the project plan, communication plan, presentations and brochures. Finally, the researcher was able to attend workgroup meetings during the implementation period and the evaluation meeting of the steering group at the end of this period. Observational notes from these meetings were made.

In sum, a multi-actor approach was adopted to generate a complete picture of the process. Multiple data collection methods were used to triangulate the data. Furthermore, a longitudinal research design was used to be able to detect potential changes throughout the process. Three data collection rounds were performed; at the start, the middle and the end of the pilot project.

The collected interview, focus group and document data was analysed using Atlas.ti (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany), following thematic analysis (Braun and Clarke, 2008; Grbich, 1999; Rapley, 2011). First, the researchers familiarized themselves with the data, by transcribing all the interview material and rereading the transcribed material. Second, initial codes were generated, which were used to search for themes. These initial codes formed an initial list of ideas about what information is in the data. As Braun and Clarke (2008) state, these codes ‘identify a feature of the data ... that appears to be interesting to the analyst’ (88). When searching for initial codes, the research question was kept in mind, but codes were primarily data driven. These initial codes were then organized in broader categories based on repeated patterns across the data set: the themes. In this phase, the analysis was refocused at a broader level and codes were sorted into subthemes and themes. After that, the (sub)themes were reviewed in the light of the coded data extracts. Finally, the themes were defined and renamed. Examples of initial codes were

business, economizing, budget, efficiency, productivity and time pressure. These codes resulted in the subtheme business-like logic. The resulting theme, this subtheme, belongs to its multiple institutional logics. In addition, this process of identifying codes, subthemes and themes resulted in the themes communication, labelling, empowerment and internalization. These resulting themes are used to structure the findings section of this article.

FINDINGS

In order to answer the research question, 'How does the presence of multiple logics affect the adoption decision-making and implementation process of an innovative practice in health care?', the main themes derived from the data analysis are used in this section.

Multiple institutional logics

Several respondents refer to the two-sided nature of the programme, including both efficiency and quality of care, when discussing motives for adoption. Respondents from the nursing population as well as managers refer to the multiple logics reflected in the programme.

Well, one of the reasons to introduce it is finding a way to improve the quality of care. But not only quality of care, also how you can realize efficiency in the ward. (internal guide, ward A)

Increasing direct patient care, but also working more efficiently...I think how can you use rooms in the best and most efficient way will benefit us. Less walking, and less searching. (senior nurse, ward B)

However, we can also see some differentiation in adoption motives that are mentioned by respondents stemming from different disciplines. First of all, nurses reported to the Nursing Advisory Board that they increasingly experience more work pressure. They feel that many additional administrative tasks are being forced upon them and they do not understand why these tasks, that withhold them from direct patient care, are necessary. The fact that they are unable to spend enough time on direct patient care is perceived as a problem and results in lower job satisfaction.

Nurses felt that they were almost communicating with the patient via checklists. That is not what nurses want, it is not nice. (Nursing Advisory Board chair)

Due to the fact that administrative tasks are being imposed on nurses, they experience a lack of empowerment. They feel that other people determine how they do their job. This results in a lot of resistance from the nurses when management tries to implement

something new. Therefore, the chair of the Nursing Board searched for a programme that would give the control over work to nurses. Exactly the fact that the 'Productive Ward: Releasing Time to Care' is not a top-down change programme, but that nurses are being empowered to reorganize and restructure their ward themselves in order to improve patient care is what appeals to her.

They [nurses] feel that a lot of work is improper and forced upon them. This causes dissatisfaction and resistance about every innovation and change. (project plan, p. 3)

If you talk about innovation in health care, it is often top-down or a management tool....employees say nice for you, but we can't work with that. (Nursing Advisory Board chair)

They [Nursing Advisory Board] were enthusiastic about involving the team in thinking along instead of letting everything come from the top ... I think that will eventually result in a better running hospital. (senior nurse, ward B)

Quality of care, another indicator of the nursing professional logic, is also reflected in reactions from the nursing perspective on the programme.

That is why the Nursing Advisory Board went looking for possibilities to improve the quality of care, but then for and by nurses. (project plan, p. 3)

There is nothing worse for a nurse than being unable to do your work right, resulting in lower quality of care. (nurse, ward A)

Besides these indicators that were closely linked to the nursing professional logic, the project plan also reflects a motive that could be linked to the business-like logic.

The Nursing Advisory Board also wanted to contribute to the strategy of the hospital by looking for more efficient ways of working. (project plan)

The hospital director, who was involved in making the adoption decision, primarily refers to rational economic motives for adoption and shows a more business-like logic. He mentions motives such as working more efficiently.

More from a business perspective, of course hospitals are confronted with economizing ... We will have to work with the people we have, there will be no additional staff. That means that you will have to work more efficiently. (hospital director)

Next to that, he also refers to problems within the organization that could be improved by the project, such as the high-perceived work pressure and agitation within the wards. Similar to the Nursing Advisory Board chair, he also refers to fact that the programme is a bottom-up implementation that empowers nurses is one of the main

reasons for adopting 'Productive Ward: Releasing Time to Care', because this addresses the needs of nurses.

What I as director find important is that this is a bottom-up innovation. Thus, I only facilitate and steer. They [nurses] are the directors and have to do the project....they embraced the project. (hospital director)

When evaluating the project at the end of the pilot period, the two logics are also represented. The health care manager refers to both logics when expressing his opinion at the end of the pilot.

It [Productive Ward: Releasing Time to Care] results in better patient care and I believe in the business case of the programme. (health care manager)

The hospital director primary refers to the business-like logic, by stressing the importance of the return on investment to project could generate. In evaluating the pilot, the director emphasizes the importance of whether the investment brings benefits towards the organization in terms of money.

We started this project with the idea that it is an economic instrument; that you can skip a dayshift because of the project. (hospital director)

On the other hand, a physician and nursing representative evaluating the programme are more drawn towards the implications the programme has for the work and care processes in the ward.

I think it is special that the project gives something back to people that deliver care, which can't be expressed in financial value. (physician, ward A)

I consider what the project brings, empowerment of nurses to be of much more importance than that it results in mayor efficiency gains. (nursing representative)

In summary, these findings suggest that 'Productive Ward: Releasing Time to Care' might indeed be perceived by the respondents as a practice that combines nursing professional logics and business-like logics.

Communication and labelling

The labelling and communication of the programme also reflects these multiple logics. The communication of the programme was adjusted to the different audiences within the hospital. The communication plan reveals that different messages were composed to

explain the programme, according to the logics of the audiences. The message to the directors and managers is 'Productive Ward is a good way for nurses to structure and organize their work themselves, fitting with the mission and vision of the hospital'. The message to the health care professionals, nurses and physicians, emphasizes the effects of the programme in terms of increased time for patient care, safety and quality of care, which fits well with the professional logic. To illustrate this, the message for nurses of the pilot wards is Productive Ward is the way you, together with your colleagues, can organize your ward in order to eventually again, within the mission and vision of the hospital, have more time for the patient. By organizing the wards well, patient safety and quality of care will improve. The project is not used to economize, it is not the intention to cut back on personnel.

In addition, the labelling of the project appears to be important. The fact that not only the logics of efficiency and productivity side of the project are being emphasized, but also the aspect of 'Releasing Time to Care' is important to engage nurses. The director even prefers not to call it 'Productive Ward', but 'Releasing Time to Care'.

I thought "Productive Ward" was a difficult label. "Releasing Time to Care" is more friendly and points out the direct customer interest....I prefer that latter name instead of productive ward or enhancing efficiency, because the latter are terms that do not ground easily with that kind of professionals. (hospital director)

The double label of the programme used in the organization, 'Releasing Time to Care: Productive Ward', seems to create some suspicion among nurses. Before the start of the project, when hearing the double label of the programme, nurses were afraid that the time they would save because of the more efficiently organized ward they would create during the project would result in cutbacks on personnel. They thought the programme would be a disguised economizing method. To prevent this perception from becoming an obstacle for implementation, the director guaranteed that any time that would be saved, could be invested in direct patient care, at least in the first year of the project. This reassured nurses and enhanced their commitment to the project.

It is not only focused on efficiency, also not in its appearance. And it works well that all the time it brings in extra will not be used for economizing. That really creates support among nurses; that they know that if they gain time they don't have to hand it in terms of shifts of hours, but that they can really put it back in patient care. That is very important for them. (internal guide, ward A)

Nevertheless, during the focus groups at the end of the pilot programme, it appeared that the labelling of the programme had some drawbacks. Several respondents, primarily from the nursing discipline, indicate that the label 'Releasing Time to Care' was misleading in the sense that because of this label they expected to see an increase in direct patient time, while in fact there were no large changes observed at the end of the pilot. In the beginning, the project title motivated them, because they

presumed direct patient time would be increased. However, the title backfired when nurses did not experience an increasing amount of time they could spend on direct patient time. Moreover, they often were more occupied with rearranging closets and measuring the efficiency of their ward for the project, than actually providing care.

The name of the project should be different next time. With the current name, wrong expectations are being created. (nurse, ward B)

However, more time for direct patient care is not visible....The title suggests something else. That is still a struggle for our team. The title suggests that you will have more time for the patients, but you're actually working on organizing your ward well. (senior nurse, ward A)

Empowerment and internalization

While empowerment of nurses is one of the core components of the programme, some ambiguities were revealed. First of all, the implementation process was top-down. While one of the core principles of the project is that nurses are empowered to make their own decisions, the decision to participate in the pilot programme was made by their supervisors.

If you're going to say that the ward team has influence in such a project, so they can decide for themselves what the ward is going to look like and have control over it, than they should also have that in the choice to participate. (internal guide, ward A)

This might have caused nurses to perceive this project as yet another top-down intervention that they did not choose for, while 'Productive Ward: Releasing Time to Care' was introduced into the organization to empower nurses. The top-down implementation of this project contradicts with this aim and with the autonomy component of the nursing professional logic.

Nurses seemed to appreciate the fact that they were finally able to determine themselves how to organize and change their ward, instead of listening to managers. Nevertheless, internal guides and project leaders notice that it is very difficult for nurses to propose solutions themselves.

They all say, finally we can decide for ourselves. But you notice that if they just get a plan how to do something that they also find that very convenient. (project leader 2)

This was supported by findings that show that nurses need a lot of support and need to be motivated by the workgroup members to be actively involved in the implementation process. An illustration of this can be found when analysing the events during the summer holiday break. This was a difficult period for both wards to remain working on

the project, because a lot of the project members were on holiday. In ward B, the motivation of nurses was extremely low during this period. Nurses were very busy with patient care because of a staffing shortage and did not feel like working on the project. Not many concrete results were visible yet, and they questioned the merits of investing so much time and effort in the project. Without many project ambassadors on site, it was difficult for them to find the motivation to keep working on the project. This is a clear signal the project was not completely internalized in that ward. Also in other periods during the implementation, nurses did not seem to be very proactive in addressing issues they wanted to improve and much of the project results depended on the work group.

If we [workgroup] ask nurses to volunteer to participate we get very little response ... I hope that nurses will feel more committed and will come up with topics themselves. And also for example go to a workgroup member and say I see you are working on this topic and I would like to contribute. (internal guide, ward B)

When evaluating the implementation process, committed and enthusiastic ambassadors of the project appear to be crucial. Many respondents express their satisfaction with the project team and workgroup members and the important role they play in successfully implementing the project. They stimulate others by showing a lot of energy and enthusiasm.

Your workgroup need to be enthusiastic and needs to be able to make the team enthusiastic. (care coordinator, ward A)

During the evaluation of the programme, this observation was confirmed by responses of workgroup members. When discussing whether nurses make use of the opportunity to be involved in decision-making, the reactions of workgroup members point in the direction that this was rarely done.

When you sit and wait, not much is coming from the ward. (nurse, ward B)

In sum, the findings indicate that institutional logics play an important role during the adoption and implementation of the programme. In the next section, these findings will be discussed.

DISCUSSION AND CONCLUSION

The goal of this study is to unravel the adoption and implementation processes of a new practice when multiple logics are present in both the organizational field and the practice itself.

First of all, the findings verified that the health care organization is indeed being confronted with multiple logics; both the nursing professional logic and the business-like logic are reported by respondents when discussing the 'Productive Ward: Releasing Time to Care' programme.

With respect to the adoption process, some respondents, managers and project leaders as well as nurses, refer to both logics simultaneously when discussing the motives of adoption of the programme. However, we can see that motives related to the nursing professional logic are dominant in the responses of nursing staff, while managers and directors primarily referred to motives related to the business-like logic. Nurses referred to aspects related to improvement in the quality of care and enhancing their own autonomy, while managers primarily mentioned arguments related to the enhancement of efficiency. Similar results were found in the evaluation of the programme. These findings are consistent with the conclusions from other researchers (e.g. Reay and Hinings, 2009).

The labelling and communication of the programme throughout the organizations seemed to play an important role in addressing these multiple logics. More specifically, the project was called 'Productive Ward: Releasing Time to Care' in the hospital, which reflects both logics. Besides that, the communication of the programme was adjusted towards the target audience. This resulted in a description of the programme stressing aspects related to the nursing professional logics, such as quality of care, empowerment and more direct patient care time, when communicating towards nurses. These elements were not explicitly mentioned in communication towards managers. These labelling and communication strategies might explain the appearance of multiple logics in the findings mentioned above. In addition, these results indicate that the programme might be a hybridized practice, incorporating multiple logics. The double labelling of the practice seemed to motivate nurses on the one hand, because 'Releasing Time to Care' appealed to their professional logic. However, this backfired when only very limited increases in direct patient time were observed. In addition, nurses struggled to make use of the room for manoeuvre they were supposed to get due to the programme. Moreover, the results show that double label also appeared to create suspicion among nurses whether it was not just another tool to enhance the productivity and efficiency which would eventually result in downsizing.

Our findings indicate that 'The Productive Ward: Releasing Time to Care' in its initial appearance is indeed an example of the hybridization of multiple logics, but in reality is primarily aimed at accomplishing goals that fit the business-like logic instead of adhering to both logics. The organization presented the programme as empowering nurses to make changes to their ward in order to increase the direct patient time, although the bottom line of the programme was increasing efficiency. Furthermore, several respondents did point at the fact that the pressure to economize in this hospital is increasing. In addition, respondents indicate that it is very difficult to engage nurses in change programmes aiming at efficiency and that these initiatives

lead to a lot of resistance in this professional group. 'Productive Ward: Releasing Time to Care' seems to be used to commit nurses to the change programme by appealing to their professional logic, while it was actually another economizing programme.

However, engaging nurses through presenting the programme as fitting with their logic did not deliver the intended results. In the beginning of the implementation process, nurses were enthusiastic and saw this innovative programme as a means for them to be empowered and improve the quality of care they deliver. Nevertheless, this perception changed. Due to the suspicion of nurses about the sincerity of the aims of the programme, accompanied with the problematic implementation process and the lack of concrete results with regard to releasing time to care, it resulted in a lack of commitment of nurses towards the programme. In the end, the nurses in the wards that participated in the pilot programme did not appear to see the value of the programme. Therefore, the programme was implemented, but not internalized by the nurses. Hence, this case of 'Productive Ward: Releasing time to care' seems to be an example of ceremonial adoption of a new practice (Kostova and Roth, 2002). This is problematic, because internalization is an important precondition for the sustainment of the innovation (Kostova and Roth, 2002).

Some limitations of this study can be indicated. First of all, we focused our study on the implementation of the pilot phase of the programme. Therefore, we are unable to observe whether our findings are consistent throughout the implementation of the full programme. However, we decided to focus on this pilot phase, because we expected that the role of institutional logics in the adoption and implementation of the practice would be most observable in the early phases of implementation. Due to the fact that only two wards were studied, external validity of this study is low. It is difficult to generalize the finding from this study to other contexts, though this was not the aim of this study. It might be interesting for future studies to investigate similar issues in other public service sectors, such as education and social care, in order to find out what logics are present in those sectors and whether they affect the innovation process. Future research on innovation in public services could take the complexity of the institutional environment into account, because this study indicated that this could affect the innovation process. Furthermore, future research is needed to enhance our understanding of hybridized practices and the ways internalization instead of only ceremonial implementation of these practices could be achieved.

In summary, the multiple logics that are expected to be present in the health care sector, nursing professional and business-like, are reflected in the findings. To answer our research question, it does seem to be more complex to successfully adopt and implement a new practice when multiple logics are at play. By hybridizing the logics in a practice, one runs the risk of sending conflicting messages that cause confusion. At the same time, focusing on one logic and neglecting the other might result in less commitment from the group adhering the neglected logic. Our results show that practices appealing to the logic of the users initially enhances their commitment and

degree of internalization of the practice, which is beneficial for the implementation process. However, in a context where multiple logics are at play, one should be careful when trying to implement a hybrid innovative practice aimed to appeal to multiple logics, because sending out multiple messages might create suspicion among the recipients of this message, which might decrease the amount of commitment and internalization.

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